Congress of the United States
Washington, DC 20515

May 21, 2004

Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
314G Hubert H. Humphrey Building
200 Independence Avenue S.W.
Washington, D.C. 20201

Dear Administrator McClellan:

The current Medicare Sustainable Growth Rate (SGR) formula for reimbursing physicians and other health care practitioners has generated negative updates every year since 2001. According to the Medicare Trustees, physicians face cuts of 5% a year from 2006 through 2012. Stop-gap legislation has prevented actual reimbursement cuts in the years 2003-2005, but next year Congress will confront the need to consider a more permanent "fix" in the formula.

Your recent public statements acknowledge the magnitude of this problem and your commitment to working toward an appropriate solution. In this context, we would like to recommend several policy adjustments the Administration could make that would lead to more accurate calculations of both the SGR target and spending that counts toward that target. While such fine-tuning will not eliminate all of the problems this flawed formula presents, it will help facilitate Congress' efforts to develop a more workable reimbursement system.

Perhaps our greatest concern is the Administration's continuing policy of including the cost of physician-administered drugs in the SGR, even though these drugs clearly are not "physician services" as defined in the law. Spending on these drugs is increasing far more rapidly than spending on physician/practitioner services, and inclusion of drug spending in the SGR increasingly distorts the calculation of actual spending that counts toward the SGR target. It simply makes sense to remove drug spending from the SGR formula, and we encourage you to take this logical step.

Additionally, the Administration's current calculation does not adequately capture the full impact of changes in laws and regulations required by the statute. For example, the Centers for Medicare and Medicaid Services (CMS) appears to have understated the impact of various new screening benefits. In addition, the impact of a number of Administration actions, such as CMS coverage decisions is excluded entirely even though these decisions may have just as great an impact on patient demand for services as a statutory change. Such changes need to be fully accounted for in the SGR calculation.

New benefits provided under the 2003 Medicare law also will require sound calculation of target spending in future years. The new drug benefit, for example, could lead to more medical visits, which in turn will generate additional tests and care to monitor the prescribed drug or provide other beneficial treatments. The same can be said of the expanded screening benefits provided by the law. While it is possible that the new screening benefits will ultimately lead to system-wide savings, it is unlikely that those savings will be realized initially in the physician fee schedule. The SGR calculation should fully account for all of these new services, but under current practices it likely will not.

The task confronting Congress in dealing with the SGR formula is formidable. Clearly, any actions the administration can take to more accurately account for the realities of spending on physician/practitioner services under the SGR formula, both as to actual spending and target spending, will facilitate Congress' efforts and to better ensure continued patient access to high quality care. Thank you for your efforts toward this end.

Sincerely,

Phil Crane
Member of Congress

Sherrod Brown
Member of Congress

Bill Shuster

Barbara Cubin

Karen Thurman

Christopher Shays

TOM TANCREDO

Tim Bilirakis

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